PRIOR-AUTHORIZATION OF LENALIDOMIDE (REVLIMID™)
Maryland Pharmacy Program
Tel#: 410-767-1455 or 1-800-492-5231 Option 3-Fax form to: 410-333-5398
(**Incomplete forms will be returned**)

Patient Information

Patient location: ____ Home; ____ Hospital___ Clinic___Office Age: _____ Date of Birth:_____/_____/_____
Patient Name:_____
MA ID#:_____ Address: _____
Tel.#:(_____) _____-_____ _____
Has Patient received Red Blood Cell (RBC) transfusions in the past? □ Yes □ No
Is Patient currently receiving RBC transfusions? □ Yes □ No
Is Prescriber registered in the Rev Assist program? □ Yes □ No
What are the prior antimyeloma therapies tried?_____
_____
Attach a dated copy of the most recent lab tests and provide test results for the following:
Platelet count: _____/mcL Absolute neutrophil count (ANC) _____/mcL
Serum creatinine: _____mg/dL; SGOT/AST or SGPT/ALT _____Direct bilirubin: _____mg/dL

Prescriber Information

Is Revlimid™ prescribed as part of a clinical study? □ Yes □ No
Specify sponsoring organization/drug manufacturer_____
Specify purpose of study: _____

Note: Off-label use or use of Revlimid™ at dosages other than recommended by FDA must be medically necessary and supported by/ documented in one of the three official compendia, the American Hospital Formulary Service Drug Information, the Micromedex/Drugdex drug database, and the U.S. Pharmacopeia.

I certify that Patient is not enrolled in any study involving the requested drug. I will be supervising the patient's treatment accordingly. Supporting medical documentation is kept on file in the patient's medical record.

_____, M.D. Prescriber's Name: _____ Date: _____
(Prescriber's signature)
Tel# (_____) – _____- _____Fax# (_____) - _____ - _____
License #: _____DEA #:_____ Specialty : _____
Address: _____

Prescription Information

Drug/Strength/dosage prescribed: _____
List diagnosis for which the drug was prescribed:
- □ Treatment of transfusion-dependent anemia due to Low-or Intermediate-1 risk myelodysplastic syndromes (MDS) associated with a deletion 5q cytogenetic abnormality with or without transient tyrosinemia of the newborn (TTN)
- □ MDS not related to 5 q deletion abnormality
- □ Multiple myeloma
- □ Other: _____

FOR INTERNAL USE

Approved: □ Denied: □ Date: _____Reviewer's Initials_____
Reason for denial: _____
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